

Globalisation & Healthcare Mission:

Steven Fouch

Introduction

He was thirty years old - only two years my senior at the time, and with a Masters in civil engineering, he was already a gifted leader at what was regarded by his own culture to be a very young age. He had an intelligent, loving wife and a growing, happy young family, and seemingly had everything to live for. When I first met him he could do little more than smile and tell me his name - his mental condition had deteriorated to that of a two-year-old in the space of a fortnight. On two occasions we had to conduct a massive manhunt to find him after he had wandered off around the streets of South London, too confused to be able to remember where he lived. On one occasion we found him wearing no more than his pyjamas on a frosty November morning three miles from his home.

During the year I spent caring for Tim and his family, I watched this young man become increasingly childlike, until he could no longer be trusted to care for himself in even the most basic of bodily needs. HIV-related dementia had robbed his wife and children of a husband and father, and his country of a future leader of industry and education long before death claimed him. And claim him it did after a long, traumatic year, his wife following him eighteen months later. To the best of my knowledge his eldest child is still healthy and virus free, but her younger brother died not long after his father.

This was neither my first, nor my most traumatic exposure to the devastation of AIDS, but it highlighted for me the global nature of this epidemic. Tim was from sub-Saharan Africa, and was only in the UK to complete a doctoral thesis. His infection had been acquired in his home country, but for more than half the Africans I met, HIV had been acquired here in the UK. HIV/AIDS may be the first disease of modern globalisation; it is certainly the most widespread and devastating. It had become apparent to me that the complex global community of which we were a part was both a causative agent in the health problems that I met daily and also was being shaped by these self same illnesses.

I must lay my cards on the table as I write this chapter. I am not a hands-on expert in what used to be called 'medical mission' - I have relatively limited overseas experience, and no qualifications in international health. I write not from first hand experience but from the experiences of those with whom I have come into contact in my various areas of work down through the years. As a nurse I have worked in the field of HIV and AIDS in the UK for many years, and as a Medical Anthropologist have experience in analysing critically the complex interplay of society, culture and health. With these limitations in mind, I have added a suggested reading list that can take the reader into this whole, complex field in more depth.

Healthcare and Mission - from Jesus to Today

*'Then He sent them out to preach the Kingdom of God and to heal the sick'*¹

It was the gospel that compelled me into nursing, and that further compelled me into working with people with AIDS at a time when this was both deeply unfashionable and rather 'beyond the pail' in most of the Christian community in the UK. The same compulsion has moved countless others down the ages, both in their homelands and across the globe.

Jesus sent out the first disciples with the commission to preach and heal. When confronted by John's disciples asking if He was the Messiah, Jesus replied *'The blind can see, the lame can walk, lepers are made clean, the deaf can hear, the dead are raised and the Gospel is preached to the poor'*. You can almost hear him adding *'so what on Earth do you think is going on then!?'* When, in Luke 4: 16 - 21, Jesus stood up in the synagogue in Nazareth, and read from Isaiah 61: 1 - 2, he proclaimed (among other things) recovery of sight to the blind, and care and freedom for the poor and oppressed. In short, healing, care for the sick and the weak and the proclamation of the Good News have always gone hand in hand. Saving people from spiritual death was one half of a mission that was also about bringing physical wholeness and restored human social relationships.

This 'wholistic' approach to mission was very much a part of the life of the early church. Examples abound of the early church caring for the sick as they travelled across the known world - both in miraculous healing and the more mundane areas of care for the chronically ill and dying. For example, during the bubonic plague epidemic of AD 256 in Alexandria, while the rest of the city fled the Christians stayed behind to care for the sick and dying, many of them paying for their compassion with their own lives.²

Our modern words 'hospice' and 'hospital' share the same route as 'hospitality', recognising that the early church took people into their own homes to care for them (many of whom were suffering from plague, leprosy and other diseases that would usually have left them outside the bounds of normal society).

As Hans Küng wrote:

*'The message of Jesus culminates in love of neighbour...In this light the young community of faith from the very beginning recognised active care of the suffering as a special task. Hence systematic care of the sick became a specifically Christian affair...'*³

This emphasis was largely lost after the 'Christianisation' of the Roman Empire under Constantine in the 4th Century, but even as late as the middle ages, monastic orders were still being established that saw care for the sick as a central ministry.⁴

The modern missionary movement has involved medical care through much of its existence, although it may be argued that, with honourable exceptions, many early missions did not see that saving lives and mending bodies was as important as saving souls. Indeed, it may arguably have been the phenomenally high morbidity and mortality among the early missionaries that persuaded some societies to begin to set up hospitals. In time those hospitals pioneered medical care for many communities in what we would now call the developing world.⁵

Today there are thousands of hospitals, clinics and healthcare projects around the globe set up and run by various Christian groups. India alone can boast over a thousand Christian hospitals, now run almost exclusively by the national church.

Globalisation, Poverty & Health

*"The poor you will always have among you."*⁶

Jesus' comment to Judas was not just a statement of fact, but also an indictment. Poverty is as real and horrifying in our day as it was in the first century, but the scale has grown beyond all imagining.

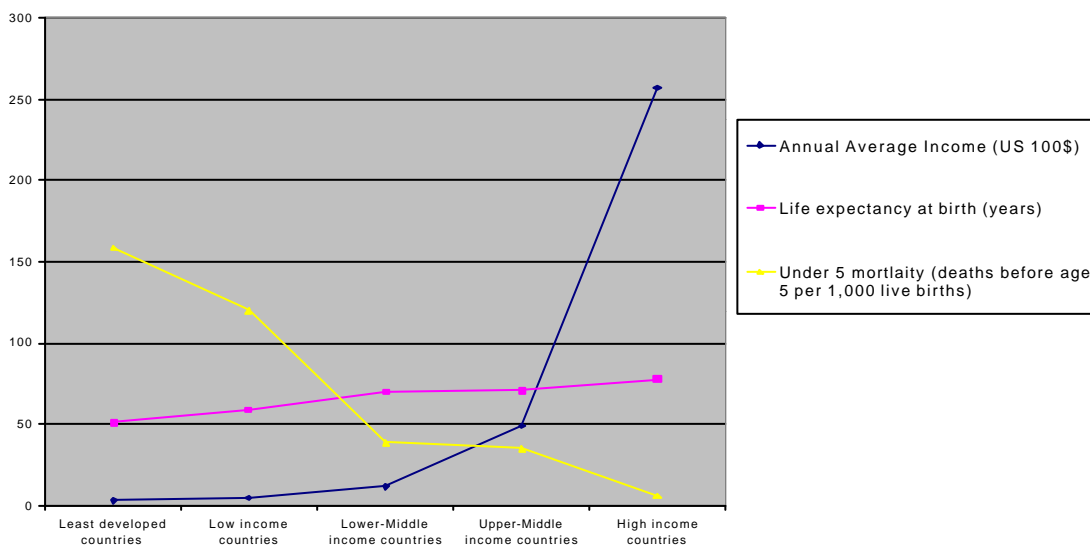
Consider these few stark facts:

- Around 1.3 billion people live in grinding poverty (income < \$1 per day)
- Growth of the world economy doubled in the twenty five years before 1998
- Developing world population numbers 4.4 billion
- Significant proportions of this population lack
 - Sanitation (3/5)
 - Clean water (1/3)
 - Health care (1/5)
 - Enough dietary energy and protein (1/5)⁷

Economic disparities both within and between countries have grown over the past decade, and incomes are lower in real terms in about 100 countries.

It is often assumed that poor health and poverty are automatically linked. Indeed, as the graph below⁸ indicates, the increasing wealth of a nation does show marked changes in many basic indicators of health such as under five's mortality rates and average life expectancy. If a nation is wealthy as a whole, it can (theoretically) afford better health infrastructures, so that more people can access healthcare. If people are wealthier, then they can afford to pay for healthcare (either directly or indirectly through taxation) so they become more healthy. More fundamentally, they can afford to eat better, and can afford better housing and sanitation, etc.

Figure 1



However, this not the whole picture. According to the International Poverty and Health Network (IPHN), the link between economic growth and health is not automatic. Poverty is multidimensional. Improving the

average health of a nation may widen inequalities, with the rich getting healthier, and the poor getting less healthy⁹.

In practice, increases in national wealth often only tend to benefit the health of those who are already wealthy. New wealth tends to congregate around those already 'better-off', while healthcare services, as they improve become more costly - both factors tending to disadvantage the poor¹⁰. Furthermore, this new wealth is often being built around the owners of factories in free trade zones, effectively tax havens for sweat shop factories, where workers are required to work long hours in poor working conditions for minimal wages. Unable to afford to eat well, and working in sometimes hazardous, often arduous conditions, the health of workers in these situations is often poor, and access to healthcare minimal if not non-existent¹¹. In these cases, increasing wealth in one sector of the population is bought at the price of dramatically reducing the health of another.

However, health also affects wealth. As people's overall health improves, so their ability to earn a living improves (where a reasonable job at a reasonable wage is available), and the drain on their incomes of medical bills is reduced. This also affects the wealth of the nation as a whole because the drain caused by an overburdened health system and a large unproductive population is reduced. A report by the Commission for Macroeconomics and Health [CMH]¹² suggests that if the basic health inequalities in the poorest nations of the world were met, over US\$ 186 billion per annum could be added to the global economy and the resultant economic uplift could take many nations out of poverty. More significantly, eight million lives would be saved each year.

To achieve this CMH calculates that all the developed nations need to give a total of \$27 billion per annum and the developing nations increase their spending on health by \$ 38 billion. If we consider that in 2001 the US mobilised \$40 billion in a few weeks to fight a war in Afghanistan, or that the costs of the proposed health development programme are equivalent to \$25 per person per year in the developed world, it becomes apparent that the missing ingredient is not money but political willpower in developed nations. However, a lack of political will (or, indeed infrastructure to sustain development of health services) on the part of the governments of many developing nations is equally a part of the problem¹³. Perhaps tackling this political apathy may be a rôle for healthcare mission work? We tend to focus on the local and the specific needs of communities, but these are affected by bigger issues with which we are often less engaged.

The focus of the secular pro-globalisation development agenda is primarily economic and at this macro level. For example, a recent initiative (The Global Health Initiative or GHI) which came out of the World Economic Forum [WEF] seeks to get businesses to tackle the health needs of both their employees and the communities in which they operate on the basis that investing in health will yield economic benefits in the long-term. This initiative is being seen as major driver in the international fight against HIV, Malaria and TB¹⁴.

Opponents of economic globalisation argue that this is naïve, as the major causes of poverty in the developing world are often these self-same businesses, and that self-interest is unlikely to ultimately benefit the poor. As the WEF was meeting in New York in February of 2002, an even bigger gathering in Porto Alegre, Brazil was looking at how to tackle corporate power on behalf of the poor¹⁵. One example of this is in the area of Intellectual Property Rights (IPR) for pharmaceuticals.

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) ensure that all pharmaceuticals are protected globally for a minimum period after they are patented to ensure that the

transnational companies that develop them are able to recoup the cost of research and development. As most of these new drugs are priced at a level above the health budgets of most third world nations or individual incomes, there is no access to many new life saving medicines for a large part of the world's poorest people. Some firms (in particular in Brazil and India) have manufactured some of these drugs without licensing agreements, making them available to developing nations at a fraction of the costs of the licensed versions. However, TRIPS has significantly limited this practice until relatively recently. A recent campaign and international court ruling has encouraged the WTO to ease some aspects of the TRIPS regulations with respect to HIV anti-retroviral drugs, and some developing world companies have reached agreements on licensing allowing them to manufacture these drugs at low cost. In addition many pharmaceutical companies have been encouraged to supply these drugs at cost to developing nations ^{16,17}.

However, these successes have not tackled the chronic under-investment in developing drugs that primarily benefit people in the developing world (e.g. treatments for common tropical diseases such as sleeping sickness, Leishmaniasis or Chaga's disease). The capitalist economic model encourages pharmaceutical companies to invest primarily in drugs that will be profitable, which in practice means those that treat primarily Western conditions¹⁸. It is more profitable to invest in drugs that correct male sexual dysfunction, for example, than those that will effectively control the current epidemic of drug resistant malaria. A recent report shows that many leading pharmaceutical companies spend less than 1% of their research and development budgets on the major illnesses of the developing world¹⁹.

Economic globalisation is a hot topic as either the cause or cure for world poverty, and thus of health inequalities. However, it is not the only factor

Globalisation and Global Health

'Be fruitful and multiply, and fill the Earth and subdue it' ²⁰

Globalisation in its wider sense also has a major impact on health, and always has done. The ancient world was globalised in a manner of speaking - especially under Rome, where travel was relatively safe, free trade encouraged and movements of knowledge, communities, cultures, philosophies and religions happened largely unchecked. Throughout the ages, these movements of people through trade, exploration, world mission and (latterly) tourism have enabled many infectious diseases to be moved from one corner of the globe to another. The lack of local resistance to these newly imported illnesses often transformed a relatively minor illness in one region to a major, life-threatening epidemic in another. Thus the devastation wrought on the native Amerindians by 16th century Spanish explorers carrying smallpox, or the impact of the common cold and influenza upon the Alaskan Inuit ²¹.

Movements of people are usually tied in with the forces of wealth and poverty, war and ecology. For example, the poor increasingly move into urban areas looking for work as rural economies collapse (e.g. as a result of the fall in coffee and cocoa prices in recent years, or as a result of drought and famine driving subsistence farmers out of their traditional homelands). This large scale urban migration, usually into crowded shanty towns and slums makes these incomers vulnerable to infectious diseases, waterborne illnesses and diseases usually thought of as diseases of affluence such as cardiovascular disease and cancer ^{* 22}. Meanwhile, sex

* For example smoking - a habit imported from the West, and supported by international tobacco firms who pump a large part of the advertising budget into the developing world, is a growing health problem among the world's poor, especially in cities.

tourists from the West have introduced HIV and other STDs (most notably into Haiti and Thailand), and are now acting as vectors to bring those diseases back to the West²³.

It is not just migration into cities that presents a health problem. People moving into new rural areas to escape war, famine or overpopulation also make themselves vulnerable to illnesses such as Leishmaniasis, Ebola, Kayasanur Forest Disease, etc. These are exacerbated by environmental damage²⁴. †

In short, the complex dynamics of human global relationships have a major impact on the social and environmental causes of disease, and on access to healthcare.

Moreover, we are naïve if we think this has no impact on life in the West. Global health issues are on our own doorstep. For example, AIDS, Malaria and TB are now endemic problems worldwide. In the UK, where I live on the borders of Kent and Greater London, we are seeing outbreaks of TB in schools²⁵, and concerns about the immanent arrival of malaria in coastal regions, where mosquitoes coming off cargo ships from the southern hemisphere are once again beginning to breed in the marshlands of Kent²⁶. Meanwhile, AIDS is now one of the leading cause of death of young men and women in the Greater London Area – many of those affected are increasingly from the sub-Saharan African communities living in and around the capital. Similar patterns can be discerned throughout the Western world.

In addition to these movements of people and disease, there is movement of cultural ideas. Western biomedicine is as culturally bound as any healthcare system[‡]. This realisation has undermined the standing of biomedicine in Western culture, so that in the post-modern West, eastern medical paradigms such as the Ayurveda and Traditional Chinese Medicine (TCM) are increasingly popular, offering an alternative to Western medicine for those who perceive its limitations, in particular in dealing with chronic illnesses. The concern that this raises for Christian mission is that the worldview of many of these healing systems is based in non-Christian religions. However, we often do not look critically at the Greco-Roman pagan origins of our own scientific Western Medicine, nor at the secular and atomistic view of the human body and health that it works from, which is hardly any more Biblical than that of Eastern Medicine.

In developing nations these and numerous other local healing traditions compete with Western Christian medical services - often to the detriment of patients. In some cultures Western medicine is only used to treat certain conditions. Some cultures believe that your soul is lost or damaged if you die in a hospital so will not seek treatment for serious conditions, while others see Western medicine as useful for treating certain acute

† For instance Kayasanur Forest Disease (KFD) in southern India is transmitted (like Lyme Disease) by ticks, whose normal hosts (small mammals and birds) were driven from their habitats due to extensive de-forestation. The clearance of the forests created scrubland that was colonised by poor agricultural communities who kept cattle that were ideal hosts to these ticks. Significantly the Indian government for many years played down the links between deforestation and KFD.

‡ Being 'culture bound' does not imply arbitrary or unproven. Rather, in acknowledging that in all spheres of human activity culture is a fundamental factor and that beliefs are not just based on 'hard evidence' but also on deeper cultural values and assumptions, we can understand how any activity we undertake, however scientifically objective we believe it to be, is affected by the social and cultural environment in which it is undertaken. To give two examples of how cultural and socio-political factors affect medical knowledge in the West, consider the cases of homosexuality and AIDS. Homosexuality was listed for many years as a mental illness in psychiatric textbooks. For a long time it was considered a treatable condition until the closing decades of the twentieth century when Gay rights campaigning and (ironically) the onset of the AIDS pandemic resulted in sea change in cultural attitudes in much of the Western world towards sexuality. Homosexuality is no longer regarded as an illness by the medical establishment and now is not only tolerated but is also being seen increasingly as an acceptable and positive lifestyle. Meanwhile medical opinion in the USA during the early 1990s redefined the point at which a diagnosis of AIDS could be made relying on certain clinical markers rather than presentation of disease. This gave people an AIDS diagnosis often before they showed any signs of illness. Being diagnosed with AIDS gave access to the benefits system in the US that a simple HIV+ diagnosis did not. In the UK, where this was not an issue, the criteria for diagnosing AIDS did not change and remained based on disease presentation. Cultural, social and political values can shape the way in which disease is diagnosed, defined and treated as much as scientific research (which is itself a culturally shaped activity).

illnesses or as a quick 'pick me up'. In some West African cultures it is believed that a man will lose his soul if his body is pierced by metal, leading to a dangerously low uptake in vaccinations for male children.

The failure in the past of some Western health practitioners to realise the interaction of local and Western health beliefs has added to the problem, and we have often assumed the primacy of our views over local beliefs. Poverty is not the sole reason people do not come to the doctor for help²⁷.

Global Crisis in Healthcare

Another big issue facing the global health environment is the emerging crisis hitting healthcare provision across the globe. We are aware in the West that our health systems are in crisis from almost daily headlines. In the UK there is a huge debate on how state funding of the National Health Service should continue as the costs of raising the funds through direct taxation escalates. Meanwhile in the US around 40 million people on middle incomes have no medical insurance but do not qualify for Medicare or Medicaid, creating a new underclass of the medically untouched and untouchable²⁸. The costs of modern health provision are a major economic stress in the West.

There are two major reasons for this and both are, in part, ironic consequences of the advances in modern medicine. Social policies and medical care have increased our life expectancies, though our overall health in old age has not increased so rapidly. The result is an increasingly aged population, a large proportion of whom will require long-term medical and/or nursing care, while the proportion of taxpayers able to fund this is decreasing²⁹.

The second problem is cost - mainly in the medical technologies that increase life expectancy. New treatments are highly expensive, but an informed, consumerist population wants access to them as soon as they become available. Consumer culture has pervaded healthcare as it has all other aspects of Western life, and consumer demands for the best treatment available, as a right, are now attitudes firmly entrenched both in Western cultural beliefs and law.

More people, requiring (and demanding) more expensive treatments with fewer taxpayers to support services is an equation that is slowly driving the Western healthcare systems to the brink of collapse³⁰.

How does this affect other parts of the globe? Obviously this is a problem facing all developed nations (not just in the West), but the developing nations have a somewhat different issues. Lacking the financial resources to provide new technologies, and with life expectancies actually being driven downwards by HIV, the issue here is how to provide even a basic service to the poor.

This is exacerbated by the fact that locally trained health professionals want to find more lucrative work either in their own cities, in private hospitals, or by emigrating to the West. One set of figures that I heard recently suggested that out of every seven doctors qualifying in one sub-Saharan nation, only one was still practising in the country a year later. This is one reason why mission hospitals still tend to be staffed by expatriates (especially in Africa where these pressures are most acute). Nurses, for example, are being actively recruited from developing nations such as Malawi and the Philippines by private recruiting agencies in the UK[§] to fill the growing gap in nurse recruitment and training from the indigenous population. The result is devastating to a

[§] Although the British Government maintains that this is not its policy.

country like Malawi, where already under resourced hospitals cannot find any staff to man their wards, threatening the well being of patients³¹.

AIDS is one of the other major new factors in this equation. It is most prevalent in the 20 - 45 age group, removing the most productive adults from the working population, thus reducing tax revenues, increasing the need for care for vast numbers of infirm adults, and killing large numbers of health professionals. In Zimbabwe, for instance, as many as one in two nursing students are HIV+.

Another factor is war. In Angola, DR Congo and Sudan for instance, hospitals and clinics have been bombed out of existence in some areas, while transport infrastructures have been equally decimated, and access to food, clean water supplies, work, etc have all been virtually eliminated by many years of civil war. In many parts of both these countries and many others, there is no health system at all. The movement of large populations of men at times of war also creates a sex industry in which the spread of HIV, hepatitis, TB and sexually transmitted diseases can accelerate dangerously.

Faced with health systems that are in many cases in a state of collapse or even non-existent, with the growing health inequalities between rich and poor, and with the impact on health of environmental and social exploitation and war, it is hard for Christian mission to engage with local communities without engaging with their health needs as well. The challenge for mission hospitals is to become sustainable and locally led. Yet when local health professionals do not want to stay, and when the local community is too poor to support a hospital or clinic by itself how can this be achieved without continued input from expatriate missionaries? Sustainable healthcare can only be achieved if all these other factors are also addressed, making communities wealthy enough and healthy enough to maintain their own healthcare infrastructures.

Chikankata Hospital in Zambia was founded on the edge of the Gwembe valley in 1946 by The Salvation Army to provide a health service for some of the poorest people in the country.

The present

As one of the epicentres of the AIDS pandemic in sub-Saharan Africa, in a situation of economic restructuring and declining net national and international aid to Zambia, the hospital in its present form had become unsustainable. At the same time the local community's existence was threatened by poverty and the growing AIDS problem.

Recognising that hospital based care was too expensive to keep pace with the demands in the long-term, the hospital turned its focus outwards to the local community itself. A programme of home-based care that is clinical, pastoral and educational has been linked to family and neighbourhood-based counselling. This has enabled the neighbourhood groups in the areas covered by the programme to recognise and respond to the problem of HIV infection themselves, rather than relying on hospital personnel. The response is seen in the expression of care for each other, and in sustained commitment to change, where this is needed, in attitudes and behaviours.

This process has happened in both low and high prevalence areas. A team approach both in hospital and in home visits to those infected, to those affected, to those in danger of being infected, and to those connected in other ways, widens the circle of prevention.

The future

Led by its traditional headmen, the community around the hospital has begun to recognise that it has the capacity to care for its own health and to accept the responsibility to do so. It can discuss its own problems, recognise their causes, decide how to solve them, and determine the priorities in the light of the resources available. This process can extend to all aspects of its healthcare and not just to HIV/AIDS.

The hospital and home care staff, most of whom are Zambian and many of whom are locally employed, have increasingly become identified with the community in this process. They are facilitating change by:

1. *drawing attention to problems*
2. *exploring concerns and hopes when people discuss what they see*
3. *encouraging the living and giving hope to the dying by working for better relationships and a more secure future*
4. *planning with the community a sustainable use of hospital resources*
5. *seeking within the church a holistic spiritual response to sickness and poverty*
6. *helping home care programmes in other areas and countries*

This process of using care to facilitate participation and change becomes community-owned rather than being the imposition of solutions from outside. The hospital and clinics become resource centres for the community. A community confidentiality develops. A degree of 'community informed consent' is found which may allow HIV testing without time-consuming pre-test counselling. The process of care resulting in change 'is as simple and yet as profound as the recognition that the love of Christ transforms'.

Mission hospitals have long been seen as the mainstay of Christian healthcare mission, and indeed in many parts of the world were the first hospitals of any kind. Inevitably, in most countries, state and private hospitals now provide the majority of services, but Christian hospitals still have a rôle, often being based in the poorest communities that the private sector does not want to service (no profit) and the state cannot afford to serve. However, most Western missions are shedding their hospitals, as they become huge cash and other resource drains. The aim for many mission agencies is now to get local churches to take over the running of these hospitals. In some cases this is successful, in others it is an ongoing struggle as a poor church and community seeks to find the resources to run a health facility that may simply not be part of its vision for its ministry to the local area. In yet others, it is impossible and outside Western input remains the only way to keep going - sometimes leading to a failure to develop local skills and leadership, perpetuating the problem, and sometimes remaining so wedded to expensive Western medical technologies that sustainable healthcare appropriate to the local setting will never be fully achieved.

Consequently, Christian hospitals, as vehicles of Christian mission are in a state of crisis at a time when effective, affordable and local healthcare are becoming greater needs than ever. It is becoming increasingly apparent that developing local skills, community and church ownership and participation and using health technologies and strategies appropriate to the local economic and cultural context are the only ways that Christian hospitals can become effective and sustainable.³²

The Emmanuel Hospital Association in India is an indigenous mission that brought together a number of previously Western run mission hospitals under an umbrella network over twenty years ago. It now includes nineteen hospitals and twenty-seven local community health projects. Its main thrust has been to develop appropriate local responses to the health needs of the vast communities it serves in North India.

Staffed almost exclusively by Indian personnel (mainly from South India) it has benefited from the two major Christian Medical colleges in Ludhiana (in the Punjab) and Vellore (in southeastern India). It has thus created a strongly Indian Christian response to health and community outreach. It has also seen as a direct result of its work, many new churches established and growing in the regions near its hospitals.

Using its expertise gained in locally running and developing not just hospitals, but community health programmes, literacy and income generation projects, it is now increasingly developing a vision for sharing that expertise elsewhere, especially into the Christian hospitals of sub-Saharan Africa, Nepal and many other parts of the globe. It has become a lead partner in the Indian Christian AIDS National Alliance, sharing its experience gained in HIV prevention and AIDS treatment programmes in North India with the rest of the country.

EHA is an example of how a previously Western run healthcare mission service has been successfully translated into a locally run and (mainly locally resourced) Christian healthcare outreach.

AIDS - A Pandemic of Globalisation

If we are to consider globalisation, health and mission in the twenty-first century, we have to consider the phenomenon of HIV and AIDS. The virus has been spread by people movements, like many other illnesses in history. However the rate of spread and its devastating consequences on a global scale mark it out a new kind epidemic - one intimately tied into the forces of modern globalisation. AIDS is perhaps a good model for the way that modern globalisation is not just shaping disease patterns and socio-medical responses, but also shaping cultural and religious ideas as well.

We have already seen how global trade, tourism, migration (economic and enforced by war and famine) have helped spread the virus with remarkable speed, and how activism at a global level has begun to see treatments being made available (at least on a limited scale) to most affected developing nations^{**},³³. Yet, undeniably, the situation is getting worse - some 40 people million have been infected in the last twenty years, half of whom have died, and new infections occur at a rate of 15,000 per day worldwide. In some countries as many as 40% of the population may be infected in the next few years, almost all of whom will suffer periods of debilitating illness before they die, effectively wiping out the 20 - 45 age group in some nations. HIV also remains inextricably linked to poverty - as an HIV positive African women recently told me, *'people do not have more sex in Africa than in Europe, we are not less moral, yet we have a worse AIDS problem. The difference between AIDS/HIV in the West and the developing world is one of poverty - why do Christians always emphasise sex as the primary prevention issue and not poverty?'*

The two most populous nations on the planet (India and China) are at the early stages of the epidemic - which still means around a million infected people in each nation - a similar proportion to South Africa twelve years ago. If the trend in South Africa is replicated so that by the middle of the next decade 20-30% of the adult population of these two nations are infected, we are looking at an epidemic the like of which history will never have seen before - nearly a billion people worldwide living with a terminal viral infection. The consequences socially, politically, economically and spiritually are too horrific to take in.

The response has, as a matter of mounting urgency, become truly global. AIDS is the only illness to have both a specific UN organisation to deal with it (UNAIDS) and, with malaria and TB (with which it co-occurs on a large scale) a Global Fund for treatment and prevention. AIDS has been an example of how governments, international agencies and other bodies can work together globally and strategically to a major health issue tackle (with limited success so far, admittedly).

Yet, the cultural ramifications of this are significant. A recent Channel Four documentary on the history of the portrayal of sex on British television noted that the eighties marked a watershed - mainly because of AIDS. Suddenly people had to talk about sexual practices and be open about the lifestyles that opened people to the risk of infection. Sex was discussed in a public way that could never have been envisioned before, even in the liberal West. Similar things are true in many other nations.

Uganda is often quoted as an example of country that has seen a marked reduction in transmission rates, mainly due to frank government education programmes in the media and schools. Significantly, a lot of this has been in partnership with churches and mission agencies, such that the role of faith based (especially

^{**} The effects of this activism are such that talk is now globally about treatment and prevention, rather than just prevention (this change of emphasis has taken a mere two years to come about between the world AIDS conference in Durban of 2000 and Barcelona of 2002)

Christian) agencies in HIV prevention as well as care, is being recognised more and more by such bodies as UNAIDS and the Global Fund for HIV, TB & Malaria^{34, 35}. AIDS is creating a doorway for Christian mission in many parts of the world.

An open attitude to talking about sex is now more prevalent in Ugandan society and in the churches, something unimaginable a decade ago. In fact, there is evidence to suggest that African and Asian attitudes to sexuality and the body have been widely influenced (not necessarily for the better) by Western attitudes as a result of the AIDS prevention campaigns that continue across the globe. Indeed, the global response to AIDS has so entrenched Western attitudes to illness, disease and treatment as a whole in developing nations that it has become more effectively the dominant discourse in all matters of health and illness than at any time in history³⁶. AIDS is not just caused by the forces of globalisation, it has become a vehicle for those forces, especially in the Westernisation of discourse and action around AIDS.

The Good News

One might conclude from all this that Globalisation can only mean bad news for the health of the poor, but this is far from the truth. The reality is more complex. The Westernisation of health practice and discourse is widely beneficial, but problematic as we have seen. Nonetheless, Western medicine is extremely effective in eliminating morbidity and mortality from many infectious diseases and in dealing with the consequences of trauma.

One example of how Western medicine and globalised technology and communications can come together beneficially is in the whole area of **telemedicine**. New technologies, from digital cameras to the Internet, allow the sharing of complex medical knowledge between centres of excellence in major cities in the developing world or the West, with smaller district hospitals and clinics.

For example, a patient presenting with an extremely unusual or rare injury can have the lesion photographed, and clinical measurements taken and e-mailed to a doctor thousands of miles away, who can review the information and send back a suggested diagnosis and treatment course or suggest other lines of enquiry in making a full diagnosis and a plan of treatment and care. This can all happen within a few hours of a patient presenting at a hospital in remote region, far from any specialist centre. In the past this was either impossible, or at best would require a lengthy referral process which would probably fall through because the patient would be unable to afford the travel, let alone the medical costs of going to a major hospital in a big city.

The impact that this kind of telemedicine is having is immense. Although more remote bush hospitals with access to e-mail only by long wave radio may not be able to make use of this technology yet, others centres are increasingly making use of this kind of networking.

International travel now means that experts can travel from different corners of the globe to provide training and input, share models of practice and provide expert consultancy to new health projects, helping the sharing of expertise and models of best practice between quite remote areas. This is not all medics from the Northern Hemisphere going to the south to impart their wisdom as the 'great white doctor', but increasingly health professionals from other southern nations sharing their knowledge with one another. For instance, India, a nation which boasts at least three Christian teaching hospitals, turns out hundred of Christian doctors, nurses, physiotherapists, dentists, pharmacists and hospital managers each year. Many go on to work in other Indian

Christian hospitals. The skills and experience that they have developed and the pioneering health work happening in so many Indian Christian health institutions are increasingly being disseminated to other parts of Asia (particularly Nepal) and increasingly to Africa and even further afield. Healthcare mission, like all mission is increasingly everywhere to everywhere.

Uganda, a nation that has seen a significant turn around in rates of new HIV infection has largely achieved this by close co-operation between churches, missions and government. ACET (AIDS Care Education and Training) is a Christian NGO that has developed some pioneering work in peer education, community based care programmes, and the production of HIV educational literature. Their experience has enabled them to share the lessons learnt with related organisations in Thailand and India, and even Eastern Europe. They have significant input into CANA (Christian AIDS National Alliance in India), have been instrumental in setting up the first Pan-African Christian AIDS Network (which first met in Gabarone in June 2002). Through a network of related Christian AIDS NGOs under the umbrella of ACET International, ACET Uganda continues to have major input into the development of co-ordinated Christian responses to HIV and AIDS across the globe, in away that a north led organisation could not.

Widespread travel, technology and economic globalisation have been major sources of health problems, but they also allow creative, local and global responses to the self-same issues.

Conclusions: - How does Christian Mission Respond to the Globalisation of Health, Illness, and Healthcare?

We face a lot of questions as we seek to tackle the vast, complex web of problems that impact on the health of the many communities we seek to reach with the Gospel. What structural issues can we/should we address to help the health situation of the poor? Where does the line come between mission, political activism and healthcare provision - or should there be a line? How can we best meet the health needs of the poor - through mission hospitals or other mechanisms - and what is suitable or even affordable? How do we fund healthcare - from local churches, charges to patients, national governments, from Christian or secular donor agencies or from individual supporters in the West? And how can we address all the questions that are raised, and still actually get on with the day-to-day business of stitching up the injured, caring for the dying, helping mothers give birth safely, and giving their children a chance to grow up healthy in body, mind and spirit?

I would suggest that there are three domains that need to be addressed further - those of economics, activism and contextualisation.

What is apparent to me is that we cannot have health as a separate issue to justice and evangelism. If, to take an example, we are to see the lives of workers in Philippine sweatshops improve, we must ensure that their health needs are being addressed, that their sense of community empowerment and awareness of their rights are heightened and that above all that they learn that there is a God who has come to save them. All this is also limited if the Western corporate giants and national third world governments are not prepared to change the way that they do business, and that issue can only be addressed by consumers and governments in the West in particular put pressure on these companies. Health, education, evangelism, local and global activism all seem necessarily to go hand in hand.

It seems an impossible task for us to address all these issues at the same time, especially when we ourselves come from environments where they are not addressed. We in the West do not see the links between our own consumer culture and our health needs, or attitude to churches (for instance, how many people talk of 'shopping around for the right church'). Can we reconcile Western medicine (which tends to objectify the body, and separate out the spiritual and socio-political and cultural causes of illness) with Christian faith? Have Westerners become consumers of faith and health, and are we guilty of exporting these Western ideas of spirituality, health and illness to our mission environments - ideas that are not of themselves necessarily based on Biblical values? I would argue that the Church worldwide, not just in the West, needs to regain a truly Biblical understanding of health, not as an absence of disease, but as a state of right relationship between God, one another and our environment. Disruptions in any of these relationships have health consequences. Ironically, many non-Western, non-Christian health systems understand the nature of health in this way far more fully.³⁷

This also raises the question of how much we engage with local health beliefs. If locals do not approach Western medicine in the way the practitioners would like (i.e. as the first recourse for all illnesses), can we find ways of bridging that gap? In fact, is it a better question to ask how do we meet people's health needs in a manner that is appropriate to their local situations and understanding of health? Most non-Western cultures do see health in the context of a spiritual and social network - and healing must encompass social and spiritual as well as physical dimensions to be truly effective.

Many illnesses seen in developing nations are known as 'culture bound syndromes'. These do not correspond to biomedical models of illness and may involve witchcraft, spirit possession, loss of face or loss of some other notion of self and physical/spiritual energy. Local witch doctors, shamans and traditional healers will often be the main recourse for treatment. By leaving these illnesses outside the boundaries of Christian medical work, we are missing the opportunity to show a God who can tackle all levels of illness. Effective Christian healthcare has always seen prayer, exorcism and other spiritual ministries as a central part of its rôle - tackling the real needs and issues of people whose cultural context for illness and healing does not fit into Western notions. It is not just the preaching of the gospel and the practice of the faith where contextualisation is an issue - it is also in the provision of healthcare.

Non-Western health practitioners (particularly, as already discussed, from India and Africa) are also a key resource. How can we facilitate more African, Asian and Latin American health professionals stay and work as missionaries to their own communities, and share their learning and perspectives with one another? How can we resource Christian hospitals, clinics and church run health initiatives to meet the needs of their own communities using local skills and knowledge as well as local resources, as well as drawing on Western skills and resources where appropriate?

These are some of the questions and challenges facing healthcare mission in the twenty-first century. Globalisation is forcing us to re-evaluate the links between economic justice, health, culture and disease, and to look again at the way that addressing these needs creates a wide-open doorway for sharing the Gospel.

Further Reading

- 'Heralds of Health', (1985) Edited by Stanley G Browne, CMF/IVP ISBN 0-906747-17-1 - *a good potted history of nineteenth and twentieth century Christian contributions to global health.*
- Diamond, J (1998) 'Guns, Germs and Steel', Vintage; ISBN: 0099302780 - *a fascinating study of how the interplay between geography, the domestication of livestock, the growth of population and the emergence of new diseases have interacted to give one region of the world dominance over others at different times in history.*
- Hellman, C (1994) 'Culture Health & Illness', Butterworth & Heinemann; ISBN 0-7506-1919-8 - *a good primer in medical anthropology and global health*
- Dixon, P (1990) 'The Truth About AIDS', Kingsway; ISBN 0-86065-880-5 (a new edition is due to be published very shortly) - *gives a clear Christian response to the global AIDS pandemic, as well as being a great source of health information.*

References:

- ¹ Luke 9 v2
- ² Davey, T F (1985) Introduction to 'Heralds of Health', Edited by Stanley G Browne, pp 1 – 11. CMF/IVP ISBN 0-906747-17-1
- ³ Küng, Hans (1976) 'On Being a Christian': Doubleday & Company, Garden City, New-York
- ⁴ Davey, Ibid.
- ⁵ Davey, Ibid.
- ⁶ John 12 v8
- ⁷ 'WHO Bulletin Spotlights Serious Inequalities in Health' – Press Release WHO/6 26 January 2000
- ⁸ 'Investing in Health for Economic Development'. Report of the Commission for Macroeconomics and Health, December 2001.
- ⁹ Haines A, Heath I, & Smith R (2000) 'Joining together to combat poverty' – BMJ; 320: 1-2.
- ¹⁰ Haines, Heath & Smith – Ibid.
- ¹¹ Klein, N (2000), 'No Logo' Chapter 9 p 195 - 229, Flamingo, ISBN 0-00-65304-0
- ¹² 'Investing in Health for Economic Development' – Ibid.
- ¹³ 'Terrorism is Not the Only Scourge' – The Economist, Dec 22 2001
- ¹⁴ 'World Economic Forum CEOs call for Greater Corporate Engagement Against AIDS/HIV, TB & Malaria' – World Economic Forum Press Release, Feb 2 2002, New York
- ¹⁵ Financial Times, February 4 2002 - 'Campaigners set to focus on world's biggest corporations'
- ¹⁶ 'African firm wins Aids drug permit' Monday, 8 October, 2001, 10:51 GMT 11:51 UK, BBC News On-line http://news.bbc.co.uk/hi/english/business/newsid_1586000/1586355.stm
- ¹⁷ 'Africa's Aids drugs debate heats up' Wednesday, 30 January, 2002, 17:17 GMT, BBC News On-line http://news.bbc.co.uk/hi/english/business/newsid_1789000/1789524.stm
- ¹⁸ Griffins, J (2002) 'Developing World Drugs' – Triple Helix, Spring 2002
- ¹⁹ www.doctorswithoutborders.org/publications/reports/2001/fatal_imbalance_short.pdf
- ²⁰ Genesis 1 v28
- ²¹ Diamond, Jared (1998) 'Guns, Germs and Steel', Vintage; ISBN: 0099302780
- ²² 'One in Five School Children Smoke in Developing Countries' – WHO Press Release WHO/51 14 August 2000
- ²³ Panos Dossier (1988), 'AIDS and the Third World' Chapter 8, p 88-91, The Panos Institute, ISBN 1-870670-04-3
- ²⁴ Hellman, C (1994) 'Culture Health & Illness', p 380 - 381, Butterworth & Heinemann, ISBN 0-7506-1919-8
- ²⁵ 23 October, 2000, 'Sharp increase in tuberculosis' - BBC News On-line, http://news.bbc.co.uk/hi/english/health/newsid_986000/986406.stm
- ²⁶ Private communication with health workers in Kent.
- ²⁷ Hellman, Ibid.
- ²⁸ Kenay JW & Christensen CM (2002) 'Disruptive Innovation - New Diagnosis and Treatment for the Systemic Maladies of Healthcare' Business Briefing: Global Healthcare, World Markets Research Centre.
- ²⁹ Meek J, 'Health crisis looms as life expectancy soars: Average ageing forecasts far too low, say scientists', Guardian Friday May 10, 2002
- ³⁰ Meek, Ibid.
- ³¹ Laurance, J 'Hands off their Nurses', The Independent Review, p12, 19 June 2002
- ³² Crespo, R (2000) 'The Future of Christian Hospitals in Developing Countries: The Call for a New Paradigm of Ministry' The CCIH Forum Issue #8 - August 2000 Special Issue: - available at <http://www.ccih.org/forum/0008-00.htm>
- ³³ 'AIDS: Hope for the Best, Prepare for the Worst', The Economist July 13 2002
- ³⁴ 'Allen, A (2002) 'Sex Change: Uganda and Condoms', New Republic, May 27 2002
- ³⁵ Christian Connections for International Health Report, May 110 2002 'Global Fund Responsiveness to Faith Based Organizations' - available at www.ccih.org
- ³⁶ Altman, D (2002) 'AIDS, Sex and Globalization', University of Chicago Press
- ³⁷ Ngong Teh, Fr. Raphael (1998) 'The Role of Traditional Medical Practitioners in the Context of the African Concept of Health Healing' - International Mental Health Workshop (available at <http://www.globalconnections.co.uk/pdfs/HealersMentalHealth.pdf>)